

## **8BAY-ARENAC BEHAVIORAL HEALTH**

**Michigan Department of Community Health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

Report Period: 1/1/06 – 3/31/06

PIHP: Bay-Arenac Behavioral Health

Program Title: Co-Occurring Disorders: Integrated Dual Disorders Treatment

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PCA#: 20700

Contract #: 20061236

Federal ID: 38-3611656

- A. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team.

The BABH PIHP Improving Practice Leadership Team (IPLT) met monthly in the second quarter of FY 2006. The team continues to provide general oversight to the IDDT Project and work on strategic planning issues related to other EBP and emerging practices. The January meeting included discussion about a system transformation grant with the MDCH Recovery Council and possible implications for the efforts of the Regional IPLT. Additional clarification was made on the wording of the recently developed IPLT Mission, Vision and Value statement. Changes were made and approved. February's meeting included a report of the 2/8/06 DCH IPLT Lansing meeting and identified issues related to strategic planning, action plans and follow-up. There was also discussion on how to focus on Evidenced Based Practices that have been in existence for a number of years and their potential impact on systems transformation. The March meeting introduced Don MacDonald as the new Regional IDDT Coordinator. There was discussion on the upcoming IDDT consultation with Patrick Boyle and the importance of having adequate representation from affiliation partners at the consultation site. Also, there was discussion of IDDT Fidelity Measurement Training. It was reported that two representatives from the affiliation were identified and will be trained to become EBP Fidelity Assessors. The individuals will be part of a cadre of assessors that be assist with the IDDT process Regionally and at other participating PIHPs.

- B. Briefly describe the Systems Change process activities during this quarter related to the integration of Mental Health and Substance Disorder services and the impact of this Evidence-Based Practice process on creating systems change.

At the monthly Integrated Services Council and Work Group meeting, work continued on IDDT implementation issues identified in the PIHP IDDT Work Plan. Specifically, the Council/ Work Group evaluated the results of the COMPASS evaluation tool completed by all BABHA Board Partners and several of the contracted Riverhaven Coordinating Agency substance use disorder treatment (SUD) providers. Affiliate partners have prioritized identified gaps for local action planning. Common areas of need identified in the COMPASS will be synthesized into a Regional Work Plan that will be completed in

the third quarter. Initial discussion began on how the Council/Work Group could collectively complete the CO-FIT 100 and work on a revision of the current Regional Consensus Document. A key benefit of the IDDT implementation process has been the creation of a collective focus on addressing co-occurring issues in the Region. The CMHSP providers are more consistently working together to address common co-occurring disorder issues such as how to create a welcoming environment and identifying training needs. Meetings held with administrative/clinical staff in the Region are educating people in the importance of recognizing how co-occurring issues impact treatment outcomes. Great care has been taken to keep the substance use disorder treatment providers involved in the IDDT process in order to continue work toward a truly integrated services delivery model. While the work plan has been developed for the CMHSP partners involved in the IDDT collaborative, it is also being shared with interested SUD treatment providers in order to help improve their co-occurring treatment capabilities.

- C. Briefly describe the changes that have occurred and milestones achieved in the last quarter. Attach the products developed.

A new IDDT Coordinator (Don MacDonald) was appointed in early March of the current reporting period. He brings twenty years of working with consumers with mental health and substance use disorder issues to the project. Negative impact was minimal as the new coordinator had previously worked for BABHA on developing the MInkoff CCISC model and he will be able to bring his prior experience to the IDDT Coordinator position. As noted in section B, the most significant milestone has been the completion of the COMPASS and the resulting identification of organizational needs.

- D. Briefly summarize consensus building and collaborative service efforts with other systems and agencies that have taken place during this quarter.

The Regional Integrated Services Coordinator and the BABHA Chief of Clinical and Program Operations, Gary Lesley, are currently involved with MDCH IDDT Work Groups. Shiawassee CMHSP CEO, Scott Gilman, is also involved with the State Work Groups. Additionally Mr. MacDonald is a participant in the Co-occurring Policy Academy sponsored by MDCH. On a regional basis the Integrated Services Council/Work Group, made up of Affiliation CMHSP Integrated Services Implementation leaders and SUD Providers, meet monthly to collaborate and build consensus for IDDT implementation.

The Riverhaven SA Advisory Council continues to be apprised of IDDT developments. A Co-occurring Disorders/IDDT report is a standing agenda item at the Advisory Council meetings. This Advisory Council continues to be supportive of CMHSP and SUD treatment staff becoming more skilled in serving persons with co-occurring conditions.

- E. Briefly describe the progress of each of the Co-occurring Disorder project goals and objectives of this quarter. Include an update on systems assessment utilizing the Co-Fit or COMPASS, the development of action plans based on this self-assessment, and progress on action plans. Please attach initial work plan/action plan based on this assessment and amendments, if any, for each of the quarters.
1. Goal: To ensure that all stakeholders are aware of the expanded implementation of the Co-Occurring – Integrated Disorders Treatment EBP across the Affiliation.

**Members of the Riverhaven Coordinating Agency Substance Abuse Advisory Council will be informed of the expanded implementation of the COD-IDDT – Ongoing** - A Co-occurring Disorder/IDDT report is now a standing report item at the Advisory Council meetings.

**Information materials on implementation of COD-IDDT will be developed and distributed to the Affiliation provider network serving persons with SPMI. Each CMHSP in the Affiliation will be responsible for ensuring that materials and information on the implementation of COD-IDDT are shared with appropriate contract providers. – Ongoing** – As new resources are identified and shared by the DCH IDDT work groups (and others), this information is disseminated to the Affiliation Partners and the SUD provider network.

**The Regional Integrated Services Workgroup and Integrated Services Advisory Council will be responsible for educating peers and consumers in their programs about the decision to implement COD-IDDT – Ongoing** – Monthly reports are received at the Integrated Services Workgroup and Advisory Council meeting on the ongoing progress of the individual CMHSP Partner IDDT efforts. Discussion is also ongoing as to how to best present the IDDT model to consumers and staff without creating resistance.

**The Regional Operations Council, made up of Chief Operating Officers from each affiliate CMHSP, will act as the workgroup of administrators that will ensure that top administration in each CMHSP is educated on the selection of this EBP for implementation across the Affiliation. – Ongoing** – Information is communicated to each of the CMHSP's regarding this block grant. Information regarding implementation issues is regularly discussed at the Regional Leadership Council monthly meetings.

2. Goal: To ensure that the appropriate leadership structure is in place to effectively implement the Co-Occurring Disorders Treatment EBP across the region.

**A COD-IDDT Coordinator with appropriate background and credentials will be hired to manage the implementation of this EBP across the region. The COD-IDDT Coordinator will be responsible for coordination of information, implementation monitoring and resource development. – Modified** – Don MacDonald, MA, LBSW, CCS, CAC-II, was appointed coordinator at BABH on 3/6/06. He will lead implementation efforts of the COD-IDDT model across the PIHP region.

3. Goal: To develop the system level building blocks necessary to support and sustain ongoing integrated services to persons with co-occurring disorders.

**Affiliate Partners complete COMPASS and provide scores (including contract agencies) to IDDT Coordinator – Done** – All Partners completed COMPASS and provided scores to the IDDT Coordinator. These scores were presented to the Integrated Services Council/Work Group to begin analysis of CMHSP and Region training/support/education/policy needs.

4. Goal: To ensure qualified trained staff are available in the Access Alliance of Michigan Access Center to screen persons for both mental illness and substance use disorders.

**Identify Access Staff dual disorder values, knowledge, and skills by having each staff complete the Co-occurring disorders Educational Competency Assessment Tool (CODECAT). – In Process** – Access staff completed the CODECAT in the 2<sup>nd</sup> Quarter of FY 2006. The supervisor evaluation of the Access group is in the process. The results of the staff level assessment will be forwarded to the COD-IDDT Coordinator for review. The Clinical Services Manager will complete the group assessment. The

COD-IDDT Coordinator will work closely with the AAM Clinical Services Manager over the next quarter to prioritize training for Access staff related to welcoming and drawing out information essential to screening for co-occurring disorders during the initial request for service.

5. Goal: To provide COD-IDDT training for all staff providing treatment and support to persons who have a dual disorder.

**No second quarter objectives for this goal.**

6. To monitor ongoing implementation of COD – IDDT EBP

**COD – IDDT Coordinator will review implementation of COD- IDDT with the CMHSP Implementation Team at least quarterly. Ongoing –** The previous Regional IDDT Coordinator and the current IDDT Coordinator have met with all CMHSP COD – IDDT Implementation Teams this quarter except one (meeting scheduled with exception early in 3<sup>rd</sup> quarter). Technical assistance is being provided by the Coordinator to help each CMHSP COD – Implementation Team begin IDDT pilots.

**Improving Practices Leadership Team and Regional Operations Council will be responsible for resolving any system level barriers that get in the way of full implementation of COD – IDDT. – Ongoing –**

As reported in the previous quarterly report the document "Promoting Collaboration Across the Human Services System" is still under review as a template for a "barrier buster" process. It is anticipated that this will to be adopted across the region relative to EBP implementation.

There have not been any system levels barriers that have required an IPLT or Operations Council response this quarter.

7. Goal: To periodically evaluate the Affiliation fidelity to the COD – IDDT EBP

**No second quarter objectives for this goal. –** However, 2 staff attended the fidelity assessment training provided by Patrick Boyle on March 22 and 23 of 2006. One of those trained will be an assessor on the state team and the other individual will provide additional support for Affiliation monitoring of fidelity. The other item related to fidelity is that the PIHP Director of Program Support Services, responsible for regional Performance Improvement, has joined the Measurement Workgroup of the Evidence Based Practice: COD-IDDT Subcommittee.

- F. Briefly describe staff training and technical assistance obtained during this quarter. Explain how these will be utilized for the program development and improving services. Please include staff coverage for the project with an organization chart showing the location of staff for this project.

Basic Principles of Integrated Treatment – Dr. Ken Minkoff , 2/9/06 – All staff from the two teams at BABH targeted to implement IDDT and representative staff from BABH Affiliates attended this training. This provided a good introduction to the basic principles of integrated treatment. Staff came away from this training having a better understanding of how their work on integrated treatment will fit into the larger system of care.

Strategic Planning and Action Steps for System Change – Dr. Christie Cline, 2/9/06 – Affiliation leaders attended this training on strategic planning for the implementation of an

integrated system of care for persons with COD. Leaders had an opportunity to discuss current implementation status and receive advice from Dr. Cline on strategies to address barriers to implementation. This provided an opportunity for Affiliation leaders who attended to get a better sense of the commitment and next steps that will be required to effectively implement this EBP.

IDDT Readiness Consult with Patrick Boyle of the Ohio SAMI – COCE: Patrick Boyle provided an IDDT Readiness Consultation to the BABHA ACT Teams on March 30. Representatives from the PIHP IPLT and representatives from all but one CMHSP in our affiliation attended this consult. Additionally one SUD provider also attended. The consultation provided an excellent evaluation of the team's readiness for IDDT implementation. Affiliation Partners were provided insight into what preparations they need to make to participate in their initial baseline IDDT Fidelity Assessment.

- G. Briefly explain the barriers and issues encountered during this quarter and the action taken to address them (administrative, legal, policy, training, outcomes, funding, budget, data encounter, grievances, etc.)

There were no major barriers encountered that required intervention during this reporting period.

- H. For projects that are at the stage of implementing COD enhanced service models, provide the following information:

1. Briefly describe the PIHP action related to data collection, fidelity and process monitoring activities to accomplish the project goal.

N/A - The BABH PIHP is not at the point of implementing the IDDT enhanced service model.

2. Describe the target population/program served during this quarter. Include the number of unduplicated individuals this quarter and the cumulative number of unduplicated individuals during this fiscal year. (If possible, include the demographic of diagnostic data relevant to the project's goals.)

N/A - IDDT services, as per the EBP fidelity, are not being provided at this time.

- I. Describe the PIHP financial and in-kind support utilized to support this project and status of sustainability planning. Is the project having problems with implementation/continuation with all the allocated resources? Should an amendment be initiated?

The year to date expenditure report is attached. No amendments to the budget are being requested at this time.

- J. Describe the activities planned to address the project's goals and objectives for the next quarter.

The results of the COMPASS will be reviewed in the second quarter at the Regional Integrated Services Advisory/Workgroup. The results of this review along with gaps/need not identified in the COMPASS will be developed into a training work plan for the PIHP region. Board Partner and SUD provider Integrated Services Implementation teams will be asked to input the work plan to ensure a comprehensive plan that will benefit the six

county behavioral health network. It is important that a regional training plan adequately interfaces with any MDCH/MACMHB trainings being offered. It is anticipated that training consultant needs will be determined once the Regional Training Plan is finalized.

As reported in the first quarter report, the Co-Fit-100 will be reviewed by the Regional Integrated Services Advisory Council/Workgroup to help identify systems issues

Work will continue on developing accurate screening and assessment measures for persons with co-occurring disorders. Efforts will also continue in the identification and capturing of relevant data on individuals with co-occurring disorders who are currently served in the network. This will continue to be worked on at a regional and local level. Appropriate screening tools for identification of a substance use disorders will be reviewed, adopted and utilized by each CMHSP in the Affiliation.

The Integrated Services Coordinator and PIHP Leadership will continue to participate at the state level in planning sessions and meetings related to the implementation of this block grant.

**Michigan Department of Community Health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-Occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

Report Period \_\_January 1, 2006- March 31, 2006

PIHP: Lakeshore Behavioral Health Alliance

Program Title: Integrated Dual Disorders Treatment

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PCA# 20708

Contract #20061244

Federal ID #38-6006063

*A. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership team.*

The Improving Practices leadership Team (IPLT) continues to meet monthly and oversee the implementation of five Evidence Based Practices: Family Psychoeducation, Integrated Dual Disorders Treatment, Parent Management Training, Recovery/WRAP, and Jail Diversion. In addition, it reviews reports from IPLT members serving on the state-wide Recovery Council and DD Practice Improvement Team. IPLT leaders have attended the DCH conferences regarding systems transformation in February and March. Representatives from the IPLT attended a pre-conference seminar on Process Benchmarking and intend to participate in the Process Benchmarking workgroup. The IPLT discussed the federal and state vision for a transformed mental health system at its February and March meetings. Proposed values, principles, and practices of a transformed mental health system have been drafted. The recommended elements of systems transformation have been presented to the PIHP senior management team. Further presentations and consensus building will take place during the present quarter with the goal of adopting an affiliation vision for transforming the Lakeshore Behavioral Health Alliance.

*B. Briefly describe the Systems Change process activities during this quarter related to the integration of Mental Health and Substance Disorder services and the impact of this Evidence-Based Practice process on creating systems change.*

The steering committee of the LBHA have been very busy this quarter with large projects and accomplishments:

1. On January 13, 2006, 40 staff from both county CMH's participated in a first COMPASS assessment and discussion. Staff were enthusiastic about having an opportunity to discuss concerns and begin work on program improvements.
2. Ten staff attended the Minkoff-Cline training in Lansing on February 9, 2006. Steering committee members attended Dr. Cline's presentation for implementation teams, and clinical leaders attended Dr. Minkoff's day-long training.
3. The steering committee continued its assessment and planning for an area-wide kick-off training with Drs. Minkoff and Cline on March 24. In preparation, Ottawa staff held a meeting with stakeholders and substance abuse providers on March 9. A similar meeting was held in Muskegon on March 13.
4. The March 24 training consisted of three events in one day:

- (a) Morning meeting of 45 CMH staff and stakeholders to begin the process of developing an area CCISC plan,
- (b.) 47 doctors and nurses attended a luncheon-training presentation with Dr. Minkoff, and
- (c.) an afternoon presentation by Dr. Minkoff attended by 125 clinical staff.

The day was a great success and helped us to further expand the interest and motivation for the clinical and administrative changes ahead.

- C. *Briefly describe the changes that have occurred and milestones achieved in the last quarter. Attach the products developed.*

Please see attached COMPASS. Drs. Minkoff and Cline provided training.

- D. *Briefly summarize consensus building and collaborative service efforts with other systems and agencies that have taken place during this quarter.*

In this first quarter of community effort, we are at a beginning stage of educating and encouraging a commitment to work on the necessary changes with our stakeholders and CMH staff. We plan a follow-up discussion on May 5<sup>th</sup> to further address collaboration and system change.

- E. *Briefly describe the progress of each of the Co-Occurring Disorder project goals and objectives this quarter. Include an update on systems assessment utilizing the Co-Fit or COMPASS, the development of action plans based on this self-assessment, and progress on action plans. Please attach initial work plan/action plan based on this assessment and amendments, if any, for each of the quarters.*

We were unable to schedule Drs. Minkoff and Cline until the end of this quarter, so this has slowed progress towards the goals for this quarter. We had hoped to be further along with a CCISC document and the establishment of work groups. However, we have scheduled a stakeholders and Lakeshore Behavioral Health Alliance staff meeting for May 5, 2006 to continue work on the CCISC document. At that time we will also determine meeting dates for clinical and administrative work groups. In addition, the steering committee will begin to review training options and curricula from other PHIPs and identify trainers who could assist with staff development.

- F. *Briefly describe staff training and technical assistance obtained during this quarter. Explain how these will be utilized for the program development and improving services. Please include staff coverage for the project with an organizational chart showing the location of staff for this project.*

Our major effort for this quarter was the three-part conference provided by Drs. Minkoff and Cline. We are currently investigating training consultants and resources to develop a curriculum for each county. It is our hope that substance abuse providers and other stakeholders will also take part in training opportunities. Leaders of our implementation team have continued to participate in state work groups. Cathy Hart, consultant, and Teri Smith, Muskegon CMH, also attended Dr. Patrick Boyle's Fidelity Training in Lansing.

- G. *Briefly explain the barriers and issues encountered during this quarter and the action taken to address them (administrative, legal, policy, training, outcomes, funding, budget, data encounter, grievances, etc).*

A barrier for both counties continues to be the development of a data system to more clearly identify dual consumers. Both counties are in the process of implementing a new computer system, which will assist in addressing this barrier. Until we have more clearly identified objectives from our work groups, we will not be able to measure treatment outcomes. CMH staff and stakeholders continue to be enthusiastic about the need for change, and welcome training and system improvement.

- H. *For projects that are at the stage of implementing COD enhanced service models, provide the following information:*

1. *Briefly describe the PIHP action related to data collection, fidelity, and process monitoring activities to accomplish the project goal.*
2. *Describe the target population/program served during this quarter. Include the number of unduplicated individuals this quarter and the cumulative number of unduplicated individuals during this fiscal year. (If possible, include the demographic of diagnostic data relevant to the project's goals.)*

Lakeshore Behavioral health is not implementing COD enhanced services at this time.

- I. *Describe PIHP financial and in-kind support utilized to support this project and status of sustainability planning. Is the project having problems with implementation/continuation with all the allocated resources? Should an amendment be initiated?*  
At this time, funds are being allocated in the manner expected.

- J. *Describe the activities planned to address the project's goals and objectives for the next quarter.*

During the next quarter, further collaboration with community stakeholders will occur. Work groups will be convened and begin to establish training and staff development priorities and contract for some educational programs as determined. Supplies will be purchased to begin further educational programs for staff and consumers as capable services are expanded. Other, more advanced, programs will be visited as determined by the work groups. A training agenda will be established during this quarter along with an action plan to address system weaknesses identified when the COMPASS was completed.

**Michigan Department of Community Health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

<b>Reporting Period</b>	<b>01/01/06 – 3/31/06</b>
<b>PIHP</b>	Community Mental Health Affiliation of Mid-Michigan
<b>Program Title</b>	Adult Mental Health Services
<b>Executive Director &amp; Address</b>	Robert Sheehan 812 E. Jolly Rd Lansing, MI. 48910
<b>Contact Person</b>	Michael Brashears, Psy.D Director: Adult Mental Health Services 517-346-8372 517-346-8370 (Fax) <a href="mailto:brashear@ceicmh.org">brashear@ceicmh.org</a>
<b>PDA, Contract #, Federal ID</b>	PDA#: 05B1CMHS-03 Contract#: Federal ID #: 38-6337733

**Michigan Department of Community Health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

<b>A</b>	<b>Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team</b>	The completion of the 1 <sup>st</sup> quarterly CMHAMM IPLT Report (Appendix A) was presented at the CMHAMM Steering Committee and approved as the process of capturing IPLT activity for CMHAMM. The report highlights multiple mental health transformation efforts at the local CMHSP and Affiliation level. Appendix A highlights this quarter's activity.
<b>B</b>	<b>System Change process activities related to the integration of Mental Health services and Substance Disorder services and the Impact of this Evidence-Based Practice process on creating system change.</b>	<p><b>Narrative:</b> The focus this quarter from a system change perspective was to conduct a gap analysis affiliation wide between the COD-IDDT EBP fidelity scale and each CMHSP existing structure and process. In addition, continued collaboration with other PIHP's to gain insight to additional system change process and barriers occurred.</p> <p><b><u>Affiliation wide activity included (but not limited to) the following:</u></b></p> <ol style="list-style-type: none"> <li>1. <b>1/4/06</b> Affiliation Core Group Meeting: focused on the adoption of the IPLT process (see Appendix A).</li> <li>2. <b>1/17/06</b> Met with Network 180 in Grand Rapids to start the preparation for our Learn &amp; Share Meeting at MDCH.</li> </ol>

		<ol style="list-style-type: none"> <li>3. <b>1/19/06</b> Held a Dual Disorder meeting at the CEI atrium with Network 180, Oakland County CMH, and Venture. The presenters were Drs. Cline and Minkoff.</li> <li>4. <b>1/24/06</b> Conference call with IDDT Fidelity Trainers coordinated by MDCH</li> <li>5. <b>2/21/06</b> MDCH IDDT all day meeting</li> <li>6. <b>3/23/06 Patrick Boyle fidelity training (two-days)</b></li> <li>7. The development of the COD-IDDT Fidelity Structure-Process-Outcome Assessment tool (SPOA) (Appendix B).</li> <li>8. The utilization of the COD-IDDT SPOA (Appendix B) affiliation wide</li> </ol>
<b>C</b>	<b>Milestones and changes</b>	<p><b>Narrative:</b> This quarter's activity focused on the completion of the newly developed COD-IDDT SPOA tool (see description in section B of this report and Attachment B). At both the affiliation and local CMHSP level a move to developing local work plans to identify barriers and solutions for COD-IDDT fidelity scale criteria was initiated.</p> <p><b><u>Affiliation wide and local CMHSP activity included (but was not limited to) the following:</u></b></p> <p><b>1/4/06</b> Affiliation Core Group Meeting  <b>1/6/05</b> Newaygo Site Visit- IDDT presentation to administrators.  <b>1/10/06</b> CEI Integrated Treatment for Dual Disorders Effective Practice book review meeting.</p>

		<p><b>1/11/06</b> CEI IDDT meeting</p> <p><b>1/13/06</b> Manistee Site Visit- Conducted a gap analysis and reviewed the core components of IDDT in relation Manistee current structure and process.</p> <p><b>1/17/06</b> Met with Network 180 in Grand Rapids to start the preparation for our Learn &amp; Share Meeting at MDCH.</p> <p><b>1/19/06</b> Held a Dual Disorder meeting at the CEI atrium with Network 180, Oakland County CMH, and Venture. The presenters were Drs. Cline and Minkoff.</p> <p><b>1/20/06</b> Dual Disorder meeting with Michael Brashears regarding the planning and implementation of IDDT within CEI.</p> <p><b>1/24/06</b> Conference call with IDDT Fidelity Trainers coordinated by MDCH.</p> <p><b>2/8/06 &amp; 2/9/06</b> MDCH meeting regarding EDP</p> <p><b>2/10/06</b> Manistee site visit. Conducted an IDDT Fidelity PowerPoint Presentation. The objective was for the Manistee staff to identify gaps and to identify IDDT components that will need to be strengthened or added to become IDDT capable.</p> <p><b>2/14/06</b> CEI Integrated Treatment for Dual Disorders Effective Practice book review meeting.</p> <p><b>2/17/06</b> Met with Michael Brashears regarding the implementation of IDDT within CEI</p> <p><b>2/21/06</b> MDCH IDDT all day meeting</p> <p><b>2/24/06</b> St. Francis CEI Adult Mental Health Services Retreat with IDDT presented to coordinators</p> <p><b>3/2/06</b> Eaton County Counseling Center-Presentation of the IDDT model to ECCC staff. Designation of ECCC IDDT team leader.</p> <p><b>3/9/06</b> Clinton County Counseling Center-Meeting with program coordinator. Presentation of the IDDT model.</p> <p><b>3/14/06</b> CEI Integrated Treatment for Dual Disorders Effective Practice book review meeting.</p>
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<b>D</b>	<b>Consensus building and collaborative services efforts with other systems and agencies</b>	<p><b>Narrative:</b> Consensus building focused on CMHAMM'S continued dialogue with Network 180 and Oakland County PIHP related to implementation and barrier resolution strategies.</p> <p><b><u>Affiliation wide activity included (but not limited to) the following:</u></b></p> <p><b>1/17/06</b> Met with Network 180 in Grand Rapids to start the preparation for our Learn &amp; Share Meeting at MDCH.</p> <p><b>1/19/06</b> Held a Dual Disorder meeting at the CEI atrium with Network 180, Oakland County CMH, and Venture. The presenters were Drs. Cline and Minkoff.</p> <p><b>3/23/06:</b> Meeting with Mark Louis (Oakland CMH)</p>
<b>E</b>	<b>Work plan progress: (Also attach initial work plan)</b>	<p><b>Narrative:</b> The creation of the COD-IDDT SPOA tool resulted in a revision of Master Work Plan, which will be submitted, to MDCH next quarter per the requirement to send work plan revisions with requested budget revisions. Appendix C provides a copy of the master work plan and samples of two local CMHSP work plans.</p>

F	<p><b>Staff training and technical assistance</b></p> <p><b>(Explain how these will be utilized for the program development and improving practices. Please indicate staff coverage for the project with an organizational chart showing the location of the staff for this project.)</b></p>	<p><b>Narrative:</b></p> <p>Training this quarter focused on a affiliation wide orientation of the COD-IDDIT fidelity scale and the newly developed COD-IDDIT SPOA (Appendix B). All CMHSP's are currently in the process of identifying COD-IDDIT training needs and an analysis of training needs associated with COD-IDDIT affiliation wide, will be included in the next quarterly report.</p>
G	<p><b>Barriers and issues encountered</b>  <b>(Also include action taken to address them)</b></p>	<p><b>Narrative:</b> Barrier identification is still ongoing and at this time continues to focus on clarifying key terms and concepts found in the COD-IDDIT fidelity scale. This quarters identified barriers include:</p> <ol style="list-style-type: none"> <li>1. The development and training of substance abuse specialist to ensure substance abuse specialists participation in all COD-IDDIT team development</li> <li>2. Clarification of the operational definitions of key program requirements found in the COD-IDDIT Fidelity Scale such as: ACT, Supportive Employment, Family Psycho-education, and Illness &amp; Recovery management. It is unclear if COD-IDDIT programs can utilize existing program models or must conform to SAMHSA EBP definitions of the above mentioned program elements.</li> </ol> <p><b>Plan to Resolve Barriers:</b> Dr. Darren Lubbers will consult Patrick Boyle to obtain clarification of the above, and will present findings at all CMHSP local workgroup meetings this quarter.</p>

<b>H</b>	<b>COD implementations status (Only for PIHP's at the implementing Stage)</b>	<b>N/A</b>
<b>I</b>	<b>PIHP financial and in-kind support (Is the program having problems with implementation/continuation, should an amendment be initiated?)</b>	<b>N/A</b>
<b>J.</b>	<b>Describe the activities planned to address the project's goals and objectives for the next quarter.</b>	<b>Narrative:</b> Appendix C provides samples of local CMHSP future work plan activity to meet the projected goals and objectives for the next quarter. Next quarter will include a copy of all five CMHSP local work plans for review.

Respectfully submitted,

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**Appendix A**  
**Community Mental Health Affiliation of Mid-Michigan**  
**Improving Practices Leadership Team**  
**Quarterly Report**  
**10-01-2005 – 02-01-06**

<b>I. IPLT Formation and Structural Development</b>	
This quarter's activity was centered on defining the role and function of the IPLT. Determining the PIHP and CMHP organization fit related to IPLT was at the center of the activity (Appendix A, illustrates a relational diagram and description of this effort).	
<b>II. Affiliation Wide Evidence Based Practice Initiatives</b>	
<i>Co-Occurring Disorders: Integrated Dual Disorders Treatment (COD-IDDT)</i>	Appendix B: COD-IDDT quarterly report provides a comprehensive update related to CMHAMM COD-IDDT Implementation progress.
<i>Parent Management Training – Oregon Model (PMTO)</i>	Appendix C: PMTO implementation status report provides an update related to CMHAMM PMTO implementation progress
<b>III. Local CMHP Evidence Based Practice Initiatives</b>	
<i>Manistee-Benzie CMH: SAMHSA Evidence Based Practice for Adult with Serious and Persistent Mental Illness tool kit review</i>	Manistee-Benzie CMH conducted a comprehensive review of the SAMHSA EBP tool kit for SPMI adults. The goal of the comprehensive review was to determine the applicability of the SAMHSA tool kit to the Manistee-Benzie service array and to initiate a gap analysis of tool kit fidelity measures and existing clinical practices.

<b>IV. MDCH Recovery Council</b>	
<p>Pamela Stants (CMHAMM-Consumer representative to the Recovery Council) Attended multiple Recovery Council meetings focused on the development of the Recovery Council Charge and review of the SAMHSA position statement defining “Recovery” principles (Appendix D).</p> <p>A more comprehensive update related to Recovery Council activity will be provided next quarter.</p>	
<b>V. Other MDCH Transformation Activity</b>	
<p>Several CMHAMM administrative and clinical staff and consumers attended several MDCH Transformation events focused on MDCH outlining state system transformation efforts, standard development, and EBP initiatives.</p>	
<b>VI. Other Clinical Standardization or CMHAMM System Transformation Activity</b>	
<i>Self Determination</i>	Appendix E: Self Determination Affiliation work group update provides a comprehensive update related to CMHAMM Self Determination Implementation activity.
<i>Developmental Disability Clinical Best Practice and EBP Identification</i>	Ingemar Johansson (Manistee-Benzie CMH) is a part of a MDCH work group focused on the identification of clinical best practices and EBP for Developmentally Disabled Consumers. A more comprehensive update related to this work groups activity will be provided next quarter

**Respectfully Submitted**

**Michael Brashears, Psy.D.**  
**IPLT Chair**  
**CMHAMM**

**Michigan Department of Community health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-Occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

Report period: January 1, 2006 to March 31, 2006  
PIHP: Macomb County Community Mental Health (MCCMH)  
Program Title:  
Executive Director: Donald I. Habkirk  
Address: 10 North Main, County Building - 5<sup>th</sup> Floor, Mt. Clemens, MI 48043  
Contact Person: Robert Slaine, Deputy Director  
Phone: 586-469-\*\*\*\* Fax 586-469-7674 E-mail: bob.slaine@mccmh.net  
PCA#: Contract #: Federal ID:

- A. Briefly describe the changes that have occurred and milestones achieved in the last quarter. Attach the products developed.
- ▶ See discussion of project goals and activities in Item "C" below.
- B) Briefly summarize consensus building and collaborative service efforts with other systems and agencies that have taken place during this quarter.
- ▶ MCCMH and MCOSA leadership teams have jointly prepared and delivered training to the leadership of provider agencies regarding the IDDT-COD implementation
  - ▶ MCCMH and MCOSA leadership teams have been represented in meetings regarding the IDDT-COD sponsored by DCH in Lansing.
  - ▶ Meetings between leadership staff of MCCMH and of Macomb DHS, Macomb ISD, and Macomb Juvenile Court/Juvenile Justice Center, and the Macomb Homeless Coalition have continued and are leading to the development of structures to support multiple projects, including the implementation of the IDDT-COD..
- C) Briefly describe the progress of each of the Co-occurring Disorder project goals and objectives of this quarter. Include an update on systems assessment utilizing the Co-Fit or COMPASS, development of action plans on the self-assessment, and progress on action plans. Please attach initial (see item by item list immediately below) work plan based on this assessment and amendments, if any, for each of the quarters.
- 1) Convene meetings with other stakeholders including MCOSA to address co-occurring disorders.  
Leaders for the Macomb County Office of Substance Abuse are essential components of the core workgroup of administrations addressing the implementation of the IDDT-COD (see items #2, 4, 6, 8, and 10 below)
  - 2) Form an on-going workgroup of administrators to address IDDT COD  
The core sub-group of the Macomb County IPL which will lead the implementation of the IDDT COD continues to include Helen Klingert (Deputy Directory of the Macomb County Office of Substance Abuse, and Jim Wargel (Director of Behavioral Health Network Operations for MCCMH). MCCMH staff member Ray Rais has begun training to be a fidelity reviewer.
  - 3) Identify a program leader for the IDDT COD implementation team
    - ▶ A project leader who would assume day-to-day leadership of the IDDT-COD implementation has not yet been found. The project leader position was originally

identified as a half-time position. It may have to be re-classified as a full-time position to obtain an appropriate professional. This will be more feasible once training and development reaches a more intensive stage.

- 4) Communicate system commitment to implementation of IDDT project to staff and agencies on the provider panels.
  - A training for Chief Executive Officers and Clinical Directors of agencies on the MCCMH Behavioral Health provider panel and on the MCOSA provider panel was held in early February, with a scheduled follow-up meeting in early April. A copy of the main Powerpoint presentation of the training is attached. Copies of the materials distributed at the training are available on request.
- 5) Participate in DCH IDDT workgroups and Policy Academy Workgroups.
  - Jim Wargel and Helen Klingert attended on-going state-wide training sessions and committee meeting associated with the implementation of the IDDT COD EBP. This participation included general IDDT Cod EBP committee meetings, as well as meetings of the Measurement sub-committee, and the Training Sub-committee. Ray Rais has begun training as a fidelity reviewer and will joining the monthly state-wide committee meetings. A member of the MCOSA staff, Mary Jo Owiesny, participates in the Training group associated with the Policy Academy.
- 6) Develop training providing overview of IDDT COD EBP and IDDT project and 7) Deliver training providing overview of IDDT COD EBP and IDDT project to administrators and leaders of agencies at the MCCMH / MCOSA provider panels
  - A training for Chief Executive Officers and Clinical Directors of agencies on the MCCMH Behavioral Health provider panel and on the MCOSA provider panel was held in early February, with a scheduled follow-up meeting in early April.
- 8) Provide training on the COMPASS to provider agency administrators and clinicians and 9) Provide training on the COFIT
  - The fidelity assessment tools included in the SAMHSA IDDT Toolkit were introduced to the leaders of agencies on the behavioral health and substance abuse provider panels maintained by MCCMH and MCOSA as part of the introductory session held in February.
  - The assessment tools associated with the CCISC will be introduced to the leaders of the agencies on the behavioral health and substance abuse provider panels maintained by MCCMH and MCOSA as part of the follow-up session in April
  - The agencies on the provider panels will be asked to use the above tools for self-assessment as part their decision-making regarding the level of COD competency (Dual Disorder Capable or Dual-Disorder Enhanced) that will be sought by that agency during the implementation project.
- 10) MCCMH/MCOSA delivers training providing overview of Co-Occurring Disorders and the IDDT project to community partners, such as the Macomb County courts, Macomb County Sheriff and Police Chiefs organization, Macomb County DHS, the Macomb County MPRI Pilot project, the Macomb ISD, etc.
  - Meetings with Macomb DHS, Macomb Juvenile Court and Juvenile Justice Center, Macomb ISD, and Macomb Probate Court continue around a variety of issues. This includes the implementatation of the IDDT-COD EBP as relevant to the various parties.
- 11) MCCMH / MCOSA complete the COFIT to assess system capability to serve persons with Co-occurring Disorders and 12) MCCMH / MCOSA assist agencies on the provider panels to develop an action plan to develop or refine capacity to serve consumers with Co-occurring disorders.
  - This COFIT will be completed as agencies on the MCCMH and MCOSA provider

panels identify their anticipated level of participation in the IDDT-COD initiative. Agencies will be surveyed after as the follow-up for the training for agency directors and clinical leadership continues.

- As agencies are surveyed regarding their self-assessments and anticipated degree of implementation of the COD EBP, discussion of developing an appropriate action plan at the agency level will take place.
- 13) MCCMH / MCOSA develop an Action Plan to enhance system capacity to serve persons with Co-occurring disorders and 14) MCCMH / MCOSA develop an Action Plan to address identified training and technical assistance needs.
- It is anticipated that several different agencies will focus on the implementation of the IDDT-COD SAMHSA Toolkit model, either through self-selection or through recruitment by MCCMH/MCOSA, leadership from these agencies will become part of a core action team that will meet with the MCCMH/MCOSA leadership teams to shape the implementation process of the EBP
  - As other agencies identify their plans to implement the COD EBP in a manner to achieve competency at the Dual Disorder Capable level, leaders from representative agencies will be asked to participate in the leadership action team as well.
  - These action plan will take final shape as agencies are surveyed regarding their anticipated level of participation and their need for training and technical assistance.
- 15) MCCMH reviews screening instruments currently available and selects appropriate screening tools for substance abuse and mental health issues in those currently using substances.
- MCCMH and MCOSA have been active participants in the state-level COD EBP sub-committees discussing the issue of screening and assessment of co-occurring disorders.
  - Leaders of the provider agencies on the MCCMH / MCOSA panels will be trained regarding screening and assessment tools during the training scheduled for early April fo 2006.
- F) Briefly describe staff training and technical assistance obtained during this quarter. Explain how these will be utilized for the for program development and improving services. Please include staff coverage for the project with an organization chart showing the location of staff for this project.
- See discussion of participation in training and committee work-groups under items C.5, C6/7 and C8/9 above.
- G) Briefly describe the barriers and issues encountered during this quarter and the action taken to address them (administrative, legal, policy, training, outcomes, funding, budget, data encounter, grievances, etc.)
- The identification of a project leader on a part-time basis continues to be problematic. The role may need to expand to full-time as the project implementation gathers intensity.
  - The continuing debate regarding appropriate screening tools and assessment procedures within the DCH state-wide IDDT-EBP sub-committees has not yet produced a uniformly acceptable product or procedure for screening for co-occurring disorders in the MCCMH and MCOSA populations. This will delay implementation of that goal and will interfere with discussions regarding further integration of the MCCMH and MCOSA access centers.
- H) For projects that are at the stage of implementing COD enhanced service models, provide the following information.
- 1) Briefly describe the PIHP action related to data collection, fidelity, and process monitoring

activities to accomplish the project goal

- See discussion under item "C8/9" above.

2) Describe the target population / program served during this quarter. Include the number of unduplicated individuals this quarter and the cumulative number of unduplicated individuals during the fiscal year. (If possible, include the demographic of diagnostic data relevant to the project's goals).

- MCCMH is not yet ready to identify consumers served according to the guidelines of that EBP.

I) Describe PIHP financial and in-kind support utilized to support this project and status of sustainability planning. Is the project having problems with implementation / continuation with all the allocated resources. Should an amendment be initiated?

- Substantial time and travel commitments for leading staff have been assumed by MCCMH in this initial quarter.
- Some of the funding budgeted for the first year of the implementation project is unlikely to be fully utilized. Hiring of a project leader has been problematic, the identification of an appropriate screening tool has been delayed (see G above), and the pace of training may not meet the anticipated pace. Movement of some of this fiscal year's funds into the following year should be considered.

J) Describe the activities planned to address the project's goals and objectives for the next quarter.

- Continuing meetings with provider agency leadership in the implementation of the IDDT EBP COD via panel-wide meetings regarding the practice.
- A survey of provider agencies regarding their anticipated level of implementation of COD programming (Dual Disorder Capable or Dual Disorder Enhanced) with decision-making guided by self-assessments utilizing the fidelity assessment tools of the SAMHSA IDDT Toolkit and the CCISC process.
- Formation of an advisory group for the IDDT-COD EBP implementation. Initial membership will be representatives from those agencies who choose to implement the IDDT-COD SAMHSA Toolkit model. Additional membership will later be recruited from those agencies who choose to implement the COD EBP at the level of "Dual Disorder Capable".
- Continuing clarification of screening and assessment tools for Dual Disorders in both the behavioral health and substance abuse networks of MCCMH. Engagement of staff from provider agencies and of access centers regarding such screening and assessment processes will begin during the follow-up meeting with the leadership of the provider agencies on the MCCMH and MCOSA provider panels. .

**ATTACHMENT C – CO-OCCURRING DISORDERS  
NARRATIVE REPORTING REQUIREMENTS**

A program narrative report must be submitted quarterly. Reports are due 30 days following the end of each quarter. (For the first three quarters, reports are due January 31, April 30, and July 31, 2006. The **final report**\* must address the entire fiscal year and is due October 31, 2006). The format shown below should be used for all narrative reports.

\* **FINAL REPORT:** Include a clear description of the actual project outcomes, the specific changes that occurred, and the impact that the project has had on the intended recipients as a result of the intervention. Did the project accomplish the intended goal? Briefly describe the results.

**Michigan Department of Community Health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

**Report Period:** January 2006 - March 2006  
**PIHP:** Network180  
**Program Title:** Mental Health System Transformation Practice Improvement Infrastructure Development Grant  
**Executive Director:** Paul Ippel  
**Address:** 728 Fuller Ave NE, Grand Rapids, MI 49503  
**Contact Person:** Jane Konyndyk  
**Phone:** 616-336-3765 **Fax :** 616-336-3593 **E-mail :** Janek@network180.org  
**PCA #:** 20710 **Contract #:** 20061245 **Federal ID:** 38-6004862

**A. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team.**

The Improving Practices Leadership Team (IPLT) at network180 has maintained the full complement of requirement membership as specified in the Request for Proposals. The IPLT is scheduled to meet monthly, and has met on three occasions. The Guiding Principles have been completed and approved by the group. The group is currently focused on the development of Action Steps. An IPLT sub group met to review EBPs that are currently in use/or in development in the network180 system of care. The Implementation Team/responsible staff for each EBP was determined, as well as data available for each. The next meeting is scheduled for the 3<sup>rd</sup> quarter.

In response to a request from members of the IPLT for more information about Evidence Based Practice (EBP), part of the February meeting was devoted to a power point presentation on EBP.

**B. Briefly describe the Systems Change process activities during this quarter related to the integration of Mental Health and Substance Disorder services and the impact of this Evidence-Based Practice process on creating systems change.**

The CCISC Initiative Agreement 2006, our third consensus document, was released to contract providers in January 2006. The Initiative Agreement 2006 provides for incentive payment for specific activities related to the advancement of this integration project. All of our providers have signed the document.

The CCISC Trainers met twice in the past quarter with a full complement of new and existing members. A topic of discussion at both meetings was the broad range of development with regard to co-occurring capability. It was determined that the name, CCISC Trainers, no longer fit the whole group, because not all of the members had developed the expertise to train. The decision was made to re-name the group the CCISC Team. The CCISC Trainers are now a subgroup of the CCISC Team.

A joint meeting of the trainers from network180, Venture, Oakland, Minkoff and Cline was held in January 2006. The purpose of the meeting was to share experiences, ideas and challenges. Another joint meeting of the trainers is being planned for the 3<sup>rd</sup> quarter.

In February 2006, Ken Minkoff MD and Chris Cline MD provided consultation to the network180 system. There were eight technical assistance visits to provider sites, one of which is funded by this grant for IDDT.

In March 2006, all of the network180 providers were invited to a meeting to give an update on activities related to the Initiative Agreement 2006. The meeting was well attended. All of the providers have scheduled or completed administration of the COMPASS and the CODECAT in 2006, and have developed Action Plans based on these self-audit tools. The IDDT providers have found IDDT to be compatible with the broader effort towards COD system capability.

The CCISC Curriculum Committee has continued to work on the development of training modules. It is anticipated that this committee will complete this project by the end of the fiscal year.

One of our IDDT providers is in the process of a re-design of their clinical programs that will include significant changes to staff orientation and staff development. Another IDDT provider has made the decision to involve their executive leadership staff in relevant co-occurring trainings. This organization has also developed a peer consultation group to support the use of Motivational Interviewing in the organization.

**C. Briefly describe the changes that have occurred and milestones achieved in the last quarter. Attach the products developed.**

As was stated previously, the CCISC Initiative Agreement 2006 was developed during the past quarter, was released in January 2006 and has been signed by all of the network180 mental health and substance use disorder providers.

During the first quarter, the decision was made to expand the CCISC Leadership Group to include one of the new IDDT providers. An original member of the CCISC Leadership Group is also a new IDDT provider. The CCISC Leadership Group has been further expanded this quarter to include two members of the CCISC Team. The purpose of the change is to improve the communication/collaboration between the executive level (CCISC Leadership Group) and the supervisor/clinician level (CCISC Team). We anticipate that this change will encourage the development of the infrastructure at provider organizations necessary to support treatment for co-occurring disorders in general, and IDDT specifically.

One of our IDDT providers marked the one year employment anniversary of a peer support specialist who works with COD clients in a group setting.

**D. Briefly summarize consensus building and collaborative service efforts with other systems and agencies that have taken place during this quarter.**

The three network180 Process Improvement Teams that came out of the COFIT all had provider representation. As was mentioned previously, the CCISC Team, the CCISC Curriculum Committee and the CCISC Leadership Group all have significant provider representation. Members of the CCISC Leadership Group have agreed to offer technical assistance to new providers. This assistance would be available to IDDT providers as well. Network180 will provide training on CCISC Principles to agencies that are new to the integration project. A number of agencies have provided training for the staff at other agencies using the CCISC Modules.

Each of the IDDT funded providers has a representative on the CCISC Team and the Motivational Interviewing Group. Two of the IDDT providers have a representative on the CCISC Curriculum Group.

As was stated previously, members of our CCISC Team met with the trainers from Venture and Oakland in January 2006. We are planning another meeting for the 3<sup>rd</sup> quarter.

At the request of Kalamazoo CMH, network180 staff met with their IDDT Coordinator to share experiences regarding the integration effort in general, and IDDT specifically.

- E. Briefly describe the progress of each of the Co-occurring Disorder project goals and objectives of this quarter. Include an update on systems assessment utilizing the Co-Fit or COMPASS, the development of action plans based on this self-assessment, and progress on action plans. Please attach initial work plan/action plan based on this assessment and amendments, if any, for each of the quarters.**

Network180 most recently completed the COFIT in January 2005. The COFIT was scheduled to be repeated in the second quarter of FY2006, however, we were not able to meet this timeline. The COFIT has been rescheduled for the 3<sup>rd</sup> quarter.

Three Process Improvement Teams were developed as a result of the 2005 COFIT. The Process Improvement Teams focused on Welcoming, Screening, and Data. The Welcoming PIT has made recommendations for changes at our administrative site and our Access Center. These changes are currently under review. The Data PIT has worked in collaboration with the Screening PIT to identify and report data elements related to the prevalence COD. This information will be collected at authorization through our Access Center and any point of access in the provider system. This data collection process was successfully piloted at our Access Center, and is now being piloted at two provider sites. System wide use of this data collection process is tied to changes to our authorization system and electronic record. It is anticipated that these changes will be completed in the 3<sup>rd</sup> quarter.

Progress on Project Goals:

1. Identify program enhancements necessary to support enhanced COD treatment and to meet project fidelity requirements. The number of providers receiving an allocation will be determined based on funds needed for each program.  
Timeline: October 2005    Status: Completed
2. Identify agency enhancements necessary for general organizational support for this evidence-based practice.  
Timeline: October 2005    Status: Completed.
3. Develop capacity and implementation plan for monitoring IDDT fidelity.  
Timeline: September – November 2005    Status: In process, network180 sent four representatives to the Fidelity Measurement Training with Patrick Boyle.
4. Develop an evaluation plan for the project.  
Timeline: September – November 2005    Status: In process
5. Implementation of IDDT enhanced programming.  
Timeline: December 2005    Status: Scheduled to begin 3<sup>rd</sup> quarter FY2006.

6. Implementation for the evaluation plan for IDDT enhanced program.  
Timeline: December 2005    Status: Scheduled to begin 3<sup>rd</sup> quarter FY 2006.

2. Improving Practices Leadership Team meets on a regular basis to review the implementation and evaluation information.  
Timeline: October 2005 – ongoing    Status: The Improving Practices Leadership Team has met on three occasions from January-March 2006.

**F. Briefly describe staff training and technical assistance obtained during this quarter. Explain how these will be utilized for the program development and improving services. Please include staff coverage for the project with an organizational chart showing the location of staff for this project.**

Network180 contracted with three agencies to provide IDDT. We held our first joint meeting in January 2006. Each of the IDDT providers has identified a team responsible for implementation. All of the providers reported staff training on topics related to the treatment of Co-occurring disorders in general, and IDDT in particular. One of the providers, Touchstone Innovare, met with Patrick Boyle in March 2006. We are planning telephone consultations for our other two providers in the 3<sup>rd</sup> quarter.

As was previously stated, IDDT is being implemented at three provider sites in the Network180 system. One provider will utilize an existing ACT Team that is made up of ten clinicians and more than 100 clients. Our second provider had intended to create a new IDDT Team, but has since decided to implement IDDT agency wide in all clinical services. Our third provider does not have case management “teams”, but does provide a case management service in residential programs. That provider plans to implement the principles of IDDT, even though they will not be able to replicate the team structure of the model.

Network180 sent four representatives to the IDDT Fidelity training with Patrick Boyle in March 2006.

**G. Briefly explain the barriers and issues encountered during this quarter and the action taken to address them (administrative, legal, policy, training, outcomes, funding, budget, data encounter, grievances, etc.).**

Two of the IDDT providers identified barriers. One reported a “freeze” on changes to their electronic clinical record. This would include changes to the electronic clinical record that support documentation of IDDT implementation. The other, a residential provider, is struggling with the application of the model to their setting. It is anticipated that the telephone consultation with Boyle will be helpful in this regard.

**H. For projects that are at the stage of implementing COD enhanced service models, provide the following information:**

1. Briefly describe the PIHP action related to data collection, fidelity, and process monitoring activities to accomplish the project goal.

- 2. Describe the target population/program served during this quarter. Include the number of unduplicated individuals this quarter and the cumulative number of unduplicated individuals during this fiscal year. (If possible, include the demographic of diagnostic data relevant to the project's goals.)**

Network180 IDDT providers are not at the implementation stage.

- I. Describe PIHP financial and in-kind support utilized to support this project and status of sustainability planning. Is the project having problems with implementation/continuation with all the allocated resources? Should an amendment be initiated?**

The CCISC Integration Project with Minkoff and Cline and the related training and leadership structure are a source of on-going in kind support for this project.

- J. Describe the activities planned to address the project's goals and objectives for the next quarter.**

1. Network180 will continue to have regular meetings with the IDDT funded providers and offer technical assistance as requested.
2. The Improving Practices Leadership Team will continue to meet and further define the role of the Team through the development of Action Plans.
3. Network180 will continue to provide support and structure of the CCISC Integration Initiative.
4. The IDDT funded providers will begin implementation in the third quarter of FY2006.
5. Network180 will continue support of the representatives involved with the IDDT Fidelity Measurement.

**Michigan Department of Community Health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

**Report Period** 1/1/06 - 3/31/06

**PIHP** Northwest Affiliation

**Executive Director** Greg Paffhouse

**Address** 105 Hall St Traverse City MI 49684

**Contact Person** Joseph Garrity

**Phone:** (231)-935-4415 **Fax** (231)-935-4495 **E-mail** Joe.garrity@nlcmh.org

**PCA#** \_\_\_\_\_ **Contract #** \_\_\_\_\_ **Federal ID** \_\_\_\_\_

**A: Systems Transformation Efforts:** The Improving Practices Leadership Team and Clinical Leadership team met with Dr. Minkoff and Cline on the 27th of January. The Charter document was reviewed at that time. Dr. Minkoff and Cline made several suggestions to revise the draft document. Revisions were made and the Charter agreement was presented to the IPLT on March 14<sup>th</sup>. The revised Charter has 5 attachments and all but the last two attachments have been completed. The two attachments yet to be completed include the initial CO-FIT assessment summary, and the 2006 Charter Agreement Action Plan based upon the regional CO-FIT assessment. The COFIT results were forwarded to the Charter Steering Committee. The Committee has been submitting their analysis of the domains included in the Charter agreement. These have been and will continue to be included in the final version of the Charter Agreement. The Charter Steering Committee will finalize the Charter Agreement in April or May of 2006. Joe Garrity presented the overall concepts of IDDT COD to the NLCMH Committee of the Whole Study Session in February 2006.

**Future Meeting Schedule**

Per our operational agreement, the IPLT will continue to meet on a quarterly basis

**Structure/membership: of the group**

**Systems Change Process:** As noted in the first report, an overall Co-occurring Disorders (COD) PIHP leadership team, consisting of members from the IPLT leadership team was formed and includes members Bill Slavin representing the PIHP, John Sternberg of West Michigan CMH, Joe Garrity of NLCMH and Sue Winter representing NMSAS. This group has continued to meet to review current status of the Charter Agreement and to analyze and implement suggestions from the COFIT. The original draft Charter was reviewed with Dr. Minkoff and Cline when they visited NLCMH in January 2006. Their suggestions have been incorporated in the current Charter revisions and Charter was again reviewed with Dr. Cline in February of 2006. The final version will be electronically submitted to Dr. Cline and Minkoff prior to implementation. The COD PIHP Leadership team will attempt to have Dr. Minkoff and Cline return this fiscal year to present to a larger group to raise awareness of

COD IDDT issues and to provide feedback and guidance to the system transformation effort. Joe Garrity, John Sternberg and Bill Slavin remain involved with State of Michigan subcommittees for training and workforce development and measurement groups that are refining the statewide systems change process for co-occurring disorders. Patrick Boyle was contacted and GOI Fidelity and IDDT COD Readiness Checklist and Fidelity measure were completed in late March and submitted to Patrick prior to his online consultation on April 13<sup>th</sup>. An Agency COMPASS for NLCMH Northwest was completed in mid January. The results are being reviewed but show that awareness has taken place in the agency. PIHP and NLCMH policies and procedures are being updated to include language on welcoming and the Accessibility Policies have been revised.

**A. Milestones:**

1. Developed Charter Regional Agreement (attached, attachments 4 and 5 need to be finished yet.)
2. PIHP continues to meet and supported Charter agreement
3. Internal training begun at NLCMH Northwest with ACT team using SAMSHA IDDT Toolkit material.
4. Clinical Leadership Team that will completed a COMPASS for NLCMH
5. NLCMH NW ACT Team completed a COMPASS  
The COC IDDT Leadership Team Completed a COFIT for NLCMH NW, West Michigan CMH, and local CA providers. COMPASS for NLCMH
6. Dr. Minkoff and Dr. Cline completed a follow up session with the PIHP Leadership Team.
7. Dr. Minkoff and Cline met with the ACT team to begin work on implementing IDDT-COD program.
8. A contract was signed with Patrick Boyle and an initial date of 4/13/06 was scheduled for phone consultation in preparation for COD IDDT training later this year.
9. A GOI Fidelity Review will be conducted prior to the phone consult as well an IDDT-COD Fidelity Review and an IDDT COD readiness checklist. This will be sent to Patrick Boyle prior to the phone consultation.

**D. Consensus Building and Collaborative Service Efforts:** The COD IDDT Leadership team met in January to complete a COFIT for the region. SA providers from the PIHP catchments area were present as were NMSAS the CA for the region. PIHP results are being compiled after participants rank order their priorities. These results are being incorporated into the working draft of the Charter Agreement as attachments 4 and 5. The working Charter agreement will provide the foundation for continued collaborative service efforts. NLCMH will attend a Quarterly Detox Review. These were initial meetings prior to the current initiative, to review current status and develop a common response. These meetings will continue in the next quarter. Staffs from several providers including the local psychiatric hospital, SA providers, CA, consumers, were invited to and attended the Dr Minkoff and Dr. Cline workshops.

**E. Project Goals: (From COD Checklist) Accomplished or Substantially Accomplished First Quarter FY 2005/2006. (Attached is revised COD-IDDT-EBP grant work plan 2005-2006)**

- 1) *PIHP convenes meetings with other stakeholders including Substance Abuse Coordinating Agencies to address co-occurring disorders.*  
Ongoing meetings are occurring with other stakeholders including local SA providers, the regional CA and local psychiatric hospital.
- 2) *PIHP identifies a program leader for Co-occurring Disorders: Integrated Dual Disorder Treatment.* Joe Garrity remains in this position
- 3) *PIHP access centers have professional staff that are trained to screen for both mental illness and substance disorders.* The NLCMH Access team has attended additional trainings with Patrick Boyle and Dr. David Mee Lee. The Access team will be included in both the Patrick Boyle phone consultation in March as well as advanced IDDT-COD training this summer with Patrick Boyle. Some of the Access Team will attend ASAM multi-dimensional assessment training. NLCMH has adopted the DALI 14 to screen for substance use/abuse concerns. Additional training will be conducted in the use of this document.
- 4) *PIHP forms an ongoing workgroup of administrators to address Co-occurring Disorders: Integrated Dual Disorder Treatment.* A PIHP leadership team has been formed to address Co-occurring disorders. The PIHP Leadership team continues to meet and has conducted two quarterly meetings. At the last meeting the working Charter Agreement was reviewed.
- 5) *PIHP forms an ongoing workgroup of clinicians to address Co-occurring Disorders: Integrated Dual Disorder Treatment.* NLCMH Northwest has formed a COD Clinical Leadership Workgroup. This team completed a COMPASS and have reviewed and completed the GOI and COD-IDDT Fidelity measurement tools. This team will meet via phone with Patrick Boyle on April 13<sup>th</sup>.
- 6) *PIHP uses the COFIT to assess where the system is with respect to its ability to serve people with Co-occurring Disorders.* The PIHP has completed a 9 county regional CO-FIT assessment for the SA and CMH provider systems on. Results are on January on 1/11/06 and 1/17/06. Results are currently being assessed and will be incorporated into the Charter Agreement.
- 7) *The PIHP develops an Action Plan that addresses co-occurring capability for the system as a context for the implementation of the COD:IDDT Resource Kit and includes identified training and technical assistance needs.* The PIHP has developed COD-IDDT-EBP Grant action plans for the next 3 fiscal years. These plans will be modified based on the results of the regional CO-FIT, NLCMH/ACT Program COMPASS, and GOI and COD-IDDT Fidelity assessments. These assessments will be periodically repeated and analyzed to measure for continuous performance

improvement. The initial CO-FIT, second COMPASS have been completed. The GOI Fidelity Assessment and IDDT-COD Fidelity assessments will be completed in March 2006 prior to the phone consultation with Patrick Boyle. David Branding and John Sternberg attended a GOI/COD-IDDT Fidelity Assessment workshop with Patrick Boyle during March 2006. Dave Branding will become part of a statewide GOI/COD-IDDT Fidelity assessment team.

- 8) *Providers use the COMPASS to assess themselves.* Per the local CA (NMSAS) the SA providers have completed the COMPASS in the 9 county PIHP area. NLCMH Northwest completed an initial COMPASS in January of 2005. A second COMPASS was completed by the NLCMH Northwest Clinical Leadership team in January 2006. The NLCMH Northwest ACT team has been identified as the IDDT-COD team. The ACT team completed a COMPASS in January 2006.
- 9) *PIHP builds ongoing training and teamwork into its system:* the PIHP has contracted with Dr. Minkoff and Dr. Cline to provide onsite consultation and training. The PIHP has contracted with Patrick Boyle to provide onsite training to clinicians during July 2006. The ACT Team received initial training from Dr Minkoff and Dr Cline in 2006. They have received addition IDDT-COD training from Joe Garrity. The ACT team will develop a process in Team Meetings where they will begin “staging” consumers and developing PCP’s based on stage of change. Access and staff attended training by Dr. Mee Lee, NLCMH plans to contract with Heather A. Flynn, PhD from the University of Michigan to provide training in Motivational Interviewing during 2006.

**F. Training and Technical Assistance:** The PIHP and NLCMH staff attended a training conducted by Patrick Boyle in Lansing in December 2005. Patrick Boyle will provide additional Training and Technical assistance on site during 2006. Members of the Access team attended workshop with Dr. David Mee Lee. Additional training will be provided by Joe Garrity MSW to the Outpatient therapy, CSM and ACT teams. No additional coverage was needed since the training took place during regular meeting times. Coverage will be arranged for the ACT team once technical training begins in July 2006, although the exact date has not been established. The outpatient team will provide coverage for the ACT team. In addition one FTE was added to the ESOP (Outpatient Emergency Services Team) to provide additional release time for Joe Garrity,

**G.** The primary barriers appear to be staff time and staffing position and available resources in the organization. As noted above an FTE was added to free up additional staff time for planning and training functions. Other barriers appear to be attitudinal and reflect past practice in providing sequential or parallel treatment for individuals with occurring disorders. Trainings will be conducted with staff utilizing outside experts and include the Minkoff site visit on 1/27/06. Additional training on co-occurring disorders will be provided during the next quarter.

Policies as identified in the COMPASS and CO-FIT do not reflect a welcoming approach for individuals with COD. Policies do not reflect a job description that identifies competencies for singly trained clinicians. An action plan based on the results of the COMPASS and COFIT will be devised and goals will be geared towards adding and amending policies to reflect Welcoming, and eventually clinical competencies. The Accessibility Policies have now been revised at the PIHP Northern Lakes CMH Level. There is a privileging committee at NLCMH; however, a co-occurring disorder privilege does not currently exist. The privileging committee will be assisted in identifying a skill set of co-occurring disorder interventions for singly trained clinicians and for co-occurring disorder specialist. Meetings have been conducted with Leadership of NLCMH and West Michigan CMH to explain the IDDT-COD approach. Resistance continues to be an issue particularly with some of the senior clinical staff. Issues concerning IDDT-COD continue to be addressed at the team level.

#### H. IDDT-COD implementation

1. The NLCMH Northwest has identified the use of the DALI 14 to improve SA screening data collection. The COD Leadership Team has worked collaboratively with the Information Technology Team to develop and implement a computerized data collection system. The PIHP will conduct initial GOI/COD-IDDT Fidelity assessments in January 2006 and will provide the results to Patrick Boyle prior to a phone consultation scheduled for 4/13/06. NLCMH has requested a GOI/COD-IDDT Fidelity review by outside consultants in July 06.
2. This area will be further addressed during the third quarter of FY 2006. The projected target population is individuals who have an SPMI and a co-occurring SA addiction/dependency diagnosis and who qualify for act services. Individuals who receive treatment from NLCMH who do not meet ACT criterion currently are eligible to receive outpatient group therapy and relapse prevention group therapy.
- I. Currently the PIHP is providing staff time to sustain the COD PIHP project. The project may have problems utilizing the full amount of the grant money. An amendment will be completed and field during the next fiscal quarter. .
- J. During the next quarter internal and external training will be provided to the ACCESS and ACT team. The PIHP will attempt to contract with Heather A. Flynn, PhD from the University of Michigan in Motivational Interviewing Techniques. The PIHP has requested an outside GOI/COD-IDDT Fidelity Assessment. The ACT team will begin to provide Staging of individual consumers during their regularly scheduled meetings. The working Charter Draft will be amended to include results of the COFIT. NLCMH is currently reviewing policies and procedures and will make appropriate changes to the document to include the concepts of welcoming and reducing barriers to treatment based on length of sobriety. NLCMH

will implement the DALI 14 SA screening and data collection purposes and will train the Access and ESOP staff in this implementation.

**Michigan Department of Community Health  
Mental Health and Substance Abuse Administration  
Improving Practices Infrastructure Development Block Grant  
Co-occurring Disorder: Integrated Dual Disorders Treatment  
Program Narrative  
Quarterly Report**

Report Period	January 1, 2006 – March 31, 2006
PIHP	Saginaw County Community Mental Health Authority
Program Title	Improving Practices Infrastructure Development Block Grant – Co-Occurring Disorder: Integrated Dual Disorders Treatment
Executive Director	Sandra M. Lindsey, CEO
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PCA#	20715
Contract#	20061260
Federal ID	38-3192817

**A. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team.**

*The 20 member Improving Practices Team met during this period on January 19<sup>th</sup> and March 16<sup>th</sup>, 2006. The Co-Occurring Work Group, composed of 27 members representing varied sites of the SCCMHA provider network, met on January 9<sup>th</sup>, February 3<sup>rd</sup>, and March 3<sup>rd</sup>, 2006.*

*The SCCMHA Charter document completed in the first quarter is now being sent out for signature and endorsement from various network participants and stakeholders. The EBP and COD/IDDT policies were amended to better include some key components and definitions during this quarter. The COD work group plan was updated this quarter.*

*The Improving Practices Team has also started review of specific Evidence-Based Practice models for SCCMHA current services, including ACT (Assertive Community Treatment), DBT(Dialectical Behavior Therapy) and SE (Supported Employment). An internal review group has been meeting weekly on DBT since March 10<sup>th</sup>; this is also a current, clinical PIP (Process Improvement Project) for SCCMHA with MDCH. The SE internal review group met on January 10<sup>th</sup> and the ACT internal review group met January 10<sup>th</sup> and April 10<sup>th</sup>. SCCMHA Improving Practices summary reports have also been provided to the SCCMHA Leadership Team (supervisors and managers who meet quarterly) and the SCCMHA Quality Team (January 20<sup>th</sup>, February 17<sup>th</sup> and March 17<sup>th</sup> meetings), since both the COD work group and Improving Practices Leadership Team activities are reported to the SCCMHA Quality Team.*

*A member of the SCCMHA Improving Practices Leadership Team is a representative on the state MDCH Recovery Council, so reports about that effort are also made to the IPL team. MDCH activities including training information is routinely shared with the group as well. The team looked at the recently issued MDCH "Family Centered Practice" policy draft, and also received EBP information relative to Older Adults from a training that a SCCMHA staff member attended.*

*SCCMHA provided CD-ROM copies of the SAMHSA tool kit CDs on ACT, SE and COD to the varied work group members and other key staff and network providers. Key SCCMHA staff continue to participate in statewide meetings and trainings relative to COD/IDDT EBP, including integrated access, training, administrative issues and policy changes. SCCMHA also initiated a network bulletin board regarding EBPs/Improving Practices located at the organization's main office site. SCCMHA continues to include Improving Practices updates in the organizational newsletters, most recently in the February edition of the SCCMHA provider newsletter. As SCCMHA is engaged in multiple EBP fidelity review to some extent, we have already raised questions and are looking at issues relative to fidelity scale conflicts or overlap in our internal improving practices oversight.*

*The SCCMHA sponsored Evidence-Based Practice literature review research project by service population continues in order to offer our provider network and stakeholders a comprehensive review of all evidence-based practices. The first publication, "A Guide to Evidence-Based Practices for Adults with Mental Illness" was issued by SCCMHA in September was widely disseminated, and the next guide regarding evidence-based practices and children, is expected to be issued within the next month.*

**B. Briefly describe the Systems Change process activities during this quarter related to the integration of Mental Health and Substance Disorder services and the impact of this Evidence-Based Practice process on creating systems change.**

*The SCCMHA COD work group has been continuing to emphasize awareness, learning and training and some expansion of membership to ensure system representation; members include key SCCMHA staff and providers, the Substance Abuse Coordinating Agency and many of their network members, as well as key stakeholder representatives, including primary consumers. The COD workgroup has enjoyed the input and active participation of several key consumer representatives. The SCCMHA COD Work Group has reviewed and will be continuing to discuss key materials from the SAMHSA tool kit as well as from MDCH regarding co-occurring disorders. The work group has also been kept abreast of statewide activities and trainings. A few staff members attended the all day Lansing Minkoff/Cline sessions February 9<sup>th</sup>; two persons attended the 2 day Patrick Boyle fidelity training on March 23<sup>rd</sup> and 24<sup>th</sup>, including one person who will become a statewide team fidelity reviewer from SCCMHA. SCCMHA also participated in the ½ day Patrick Boyle consultation on March 30<sup>th</sup>; 30 clinicians from 6 different SCCMHA program teams participated. SCCMHA expects that at least four of these teams will become DDE (dual diagnosis enhanced) and subject to fidelity reviews early in 2007; other SCCMHA programs/providers will be expected to become dual diagnosis capable*

(DDC). *It is too early to discuss specific problems with implementation as the target date is October 1, 2006. However, to date, the model has been positively received by participating SCCMHA staff, providers and key stakeholders. The SCCMHA Continuing Education Supervisor has been added to the COD workgroup and has begun work on dual disorder training modules to be implemented as part of the SCCMHA clinical orientation and training program effective October 1, 2006; this will assist SCCMHA to meet the training requirement in the fidelity scale and allow for reduced dependence upon external trainers and embed the practice in the service array.*

**C. Briefly describe the changes that have occurred and milestones achieved in the last quarter. Attach the products developed.**

*The revised EBP and COD policies of SCCMHA, the final COD Charter Document, and recent reports to the SCCMHA Quality Team are attached to this report. Additional staff training occurred through access to statewide trainings, and key staff and provider representatives received fidelity training and consultation this quarter.*

**D. Briefly summarize consensus building and collaborative service efforts with other systems and agencies that have taken place during this quarter.**

*SCCMHA has been very encouraged by the support, energy and engagement of the COD work group members, as well as the improving practices leadership team members in this process to date. There is strong agreement on concepts and continued healthy discussion about comprehension of content, impact on systems and next steps in implementation. There is significant mental health and substance abuse provider representation and direct involvement in all activities to date. Seven (7) members of the SCCMHA Improving Practices Team also serve on the COD workgroup, including one stakeholder member who is a representative of the Association for Children's Mental Health, so there is continuity and depth of understanding. Several team members are both mental health and substance abuse coordinating agency contract agencies. Recovery has been a theme of discussion for the group as well, and a MDCH Recovery Council member serves on the SCCMHA Improving Practices Leadership Team. The COD/IDDT implementation is now a standing agenda item now for the regular joint quarterly meeting of SCCMHA and local Substance Abuse Coordinating Agency leadership beginning in 2005. To date, the COD Charter document issued by SCCMHA through the COD work group and Improving Practices Leadership Team has been officially endorsed by the SCCMHA Board as well as the SCCMHA Citizens Advisory Council. Planned charter endorsers include judges, jail, hospitals, health plans and varied Saginaw County leadership. Signatories to the document will include the actual members of the SCCMHA and substance abuse service provider network.*

**E. Briefly describe the progress of each of the Co-occurring Disorder project goals and objectives of this quarter. Include an update on systems assessment utilizing the Co-Fit or COMPASS, the development of action plans based on this self-assessment, and progress on action plans. Please attach initial work plan/action plan based on this assessment and amendments, if any, for each of the quarters.**

*The SCCMHA COD Work Group is just beginning to review the CO-FIT as this time. SCCMHA continues to concentrate on all network-wide primary clinicians (about 150) becoming fully trained in the COD/IDDT model and obtaining baseline assessment information for providers and programs. (Thus far, one provider has completed the COMPASS and shared information regarding results of implementation planning with the COD Workgroup as indicated below.) ACT has completed three COMPASS assessments to date; this contractual provider organization has had earlier orientation and engagement in the COD/IDDT area through their organizational contractual affiliation with other PIHPs, which has already been of benefit to the SCCMHA COD project.*

**F. Briefly describe staff training and technical assistance obtained during this quarter. Explain how these will be utilized for the program development and improving services. Please include staff coverage for the project with an organizational chart showing the location of staff for this project.**

*Since our primary mode of training staff and providers to date has been for them to attend state offered training, not all primary clinicians have yet been fully trained. SCCMHA will be working on data collection as well as staff training again in the coming quarter. Staff coverage has not yet been determined, except that there is anticipation that piloting will occur with two in-house case management teams with the SCCMHA Community Support Services, as well as the contracted ACT program and ICM (Intensive Case Management) programs. However, any chart provided in the future will include all provider network contracts from multiple external agencies and will be product of the team development and priorities, including dual diagnosis enhanced and dual diagnosis capable distinctions.*

*SCCMHA has made a significant effort to provide key written materials to the team members, including SAMHSA TIPs, COCE materials, basic principles of COD/IDDT, and SAMHSA tool kit information detail.*

**G. Briefly explain the barriers and issues encountered during this quarter and the action taken to address them (administrative, legal, policy, training, outcomes, funding, budget, data encounter, grievances, etc.).**

*Completing basic training for all appropriate persons is still one system challenge. getting all persons completely trained is still in progress, however, SCCMHA is pleased with the amount of time and staff attention to training that already taken place. A second barrier is data collection; SCCMHA is still in the process of implementing new information system software, and the resources needed to look at current EBP data/baseline, as well as begin to develop new information system data capture plans for improving practices has not yet been able to be SCCMHA's priority for this project. This is now expected to be addressed in the third quarter; a planning meeting is expected to be held in June. A third barrier is still overall staff resources; this will be continual challenge for SCCMHA as some caseloads are still quite high, some staff are responsible for multiple areas of job scope independent of improving practices, and there are many competing priorities within the current SCCMHA network and for administration.*

*There is, however, a high level of commitment on the part of SCCMHA for this*

*implementation effort, as demonstrated by SCCMHA's foray into literature research and other current endeavors referenced earlier; we do expect to overcome these recognized barriers as a part of the work plan that will be revised as needed.*

**H. For projects that are at the stage of implementing COD enhanced service models, provide the following information:**

*SCCMHA is not yet at this level of implementation; we are targeting October 1, 2006 at four provider program sites for implementation based on fidelity requirements of the COD/IDDT EBP model.*

**1. Briefly describe the PIHP action related to data collection, fidelity, and process monitoring activities to accomplish the project goal.**

*SCCMHA has identified the person who will be taking a leadership role in fidelity training. As part of the work plan effort, SCCMHA has begun to review the fidelity tool components – both organizational and treatment - with COD work group members, SCCMHA clinical leadership and management staff.*

*As mentioned previously, EBP data collection planning is planned to occur now in the third quarter of this fiscal year. SCCMHA has a new IS system direction that is being installed this summer and is expected to nicely accommodate the needs of COD/IDDT clinical documentation and reporting.*

**2. Describe the target population/program served during this quarter. Include the number of unduplicated individuals this quarter and the cumulative number of unduplicated individuals during this fiscal year. (If possible, include the demographic of diagnostic data relevant to the project's goals.)**

*There is no data yet to report based on SCCMHA current implementation status. We would expect to report data beginning October 1, 2006 given the time frames in our current COD implementation work plan.*

**I. Describe PIHP financial and in-kind support utilized to support this project and status of sustainability planning. Is the project having problems with implementation/continuation with all the allocated resources? Should an amendment be initiated?**

*Significant staff and provider network time has already been invested in this project. SCCMHA has provided space for direct hosting of meetings as well as national speakers for COD/IDDT training, and has also invested resources in literature research relative to overall EBP practices and information. SCCMHA has also provided clerical and copying support costs. No project amendment is being submitted at this time, but it is expected that a budget revision will be submitted within the coming quarter yet for FY 06.*

**J. Describe the activities planned to address the project's goals and objectives for the next quarter.**

*The SCCMHA COD work group will be continuing to review and amend its work plan in the coming quarter. We anticipate the completion of COMPASS and Co-Fit assessments along with completion of needed preliminary training, development of data capture methods, and IDDT/COD training module development within the SCCMHA continuing education program in the next quarter.*

- 1) Continued integration of Access activities: Since the Access Center integrated on October 1<sup>st</sup>, 2005, efforts to further integrate and cross-train staff have continued. Former SA assessment specialists and MI assessment specialists have been assigned to work as teams for the second quarter to train each other on assessment, software, and authorization processes. A new, integrated protocol manual is being written. The IDDT Coordinator is participating in the COCE Technical Assistance on screening and assessment requested by Network 180 to attempt to finalize a state-wide screening tool. Issues have been identified in providing COD assessment and referral after hours, and the IDDT Program Subcommittee will consider solutions in the next quarter.
- 2) Formation of a Kalamazoo County Provider Steering Committee: Kalamazoo County contracts out for all MH and SA services, unlike other counties in the PIHP. Since clinical representatives from each provider agency would have overwhelmed the IPLT and weighted it too heavily towards Kalamazoo County, an IDDT Provider Steering Team was formed to implement COD and IDDT services at provider agencies in Kalamazoo. Members are in process of identifying goals, prioritizing those goals, identifying barriers, and determining which goals will be the focus of an action plan for the next 6-9 months.
- 3) Integration of consumers at the highest level of authority: Southwest Affiliation employs several consumers in professional or paraprofessional roles, many of whom are addressing co-occurring recovery personally (70% of the peer group, Peers for Wellness and Recovery, report having a co-occurring disorder). In the second quarter, Southwest Affiliation hired its first IDDT Peer Support Specialist, Karrie Cross. Since being hired, Karrie has established two open Dual Recovery Anonymous (DRA) meetings in Kalamazoo (Mondays and Fridays) and is working with an Allegan consumer to open a DRA meeting in Otsego. Additionally, a new member of the IPLT and IDDT Subcommittee, Kevin Lindsley, has joined the group. Kevin is in COD recovery and serves, along with Karrie, on the Peers for Wellness and Recovery group.

- 4) Revision of Charter and Adoption of Strategic Plan by IPLT and Executive Directors: COD Charter with ammended action plan was completed in March with approval by the IPLT and IDDT Subcommittee in April. It will be forwarded to Affiliate executive directors for signature in May.

## **B. System Change Process Activities**

See above.

## **C. Milestones Achieved**

- 1) Hiring of IDDT Peer Support Specialist: Karrie Cross brings with her a wealth of recovery experience, adding credibility to our IDDT implementation efforts. Karrie is preparing presentations to local stakeholders on Dual Recovery Anonymous, pursuing seeking grant funding for the development of a Recovery Shoppe with recovery-based collateral materials (books, workbooks) and art and crafts produced by consumers in recovery. Karrie will also work jointly with Jennifer to deliver COD trainings to clinical teams, stakeholders, and community members
- 2) Involvement in Fidelity Assessment team and process: In the second quarter Southwest Affiliation contributed two members to the IDDT Fidelity Team, MiFAST. David Petts and Jennifer Harrison were trained to be Fidelity Assessors. Jennifer will be the first MiFAST member to shadow a Fidelity Team in Findlay, OH on May 11<sup>th</sup>.
- 3) Leadership in “training library” development: Kalamazoo has taken the initiative in contacting national speakers to video-tape trainings on COD topics, and then providing copies and smaller training modules to others interested throughout the state. Dr. David Mee-Lee’s training on April 11<sup>th</sup> – 12<sup>th</sup> was the first example of that, resulting in 10 hours of good quality video-tape.
- 4) Completion of COD-specific RFIs to ODCP for Kalamazoo and St. Joseph Counties: RFIs to implement a COD specialty team at a Federally Qualified Health Clinic, Family Health Center, and pilot two IDDT teams in Kalamazoo and St. Joseph Counties, was submitted to ODCP on February 28<sup>th</sup>.
- 5) Submission of COD-specific SAMHSA Peer-to-peer Recovery Grant to form a peer-run service agency to provider Recovery Management and other Recovery-based services to COD consumers in Kalamazoo County: SAMSHA requested submissions for Peer-to-peer recovery services. See abstract for the project submitted, which was supported by Janet Olsefski and Governor Jennifer Granholm in letters of support.

## **D. Consensus Building**

- 1) Meeting with each Affiliation Executive and Clinical Director and information-sharing about history and needs: IDDT Coordinator, MIA and SA Deputy Directors all met with the Executive and Clinical Directors of each County to discuss history and efforts in place, as well as goals and individual County needs going forward.
- 2) Involvement of consumer and family member voice in IDDT Steering Committee (IPLT) and IDDT Program Subcommittee: see above
- 3) Integration of COD representation in Jail Diversion, Michigan Prisoner Return Initiative, and other corrections-related projects with high COD prevalence: IDDT Coordinator is now part of the Jail Diversion, and MPRI team, and has met with parole and probation, jail clinicians, Office of Community Corrections, Circuit Court, and KPEP to explain COD services and involve corrections as stakeholders.

- 4) Integration of COD representation in Meth Task Forces, which include prevention, law enforcement, education, and primary health care services throughout the Coordinating Agency: Meth prevention and intervention is a significant priority in SW Michigan, since all three of the top three Counties for Meth busts in 2005 are in the Kalamazoo PIHP or CA (Allegan, Kalamazoo, Barry). IDDT Coordinator has met at each County's Meth Task Force to involve stakeholders from law enforcement, education, prevention, and physical health as stakeholders.

#### **E. Utilization of Systems Assessments Update**

- 1) COMPASS: The COMPASS program level self-evaluation has been reviewed and distributed to each County in the Affiliation for completion by May. The COMPASS has also been distributed to the Kalamazoo County Access Center, 5 Case Management Agencies, a Primary Substance Abuse Provider, and Ministry with Communities, a local social service agency to homeless adults and families, also to be completed in May. Provider agencies completing COMPASS assessments will not report scores to KCMHSAS unless they chose, but will rather contact IDDT Coordinator when COMPASS is completed. Each agency and county will be responsible for identifying at least three action items to focus on improving practices over the next 6-9 months.
- 2) CO-FIT: The CO-FIT will be completed by the IDDT Program Subcommittee (with representation from all Counties in the Affiliation) at the June meeting.

#### **F. Training and Technical Assistance**

- 1) Development of Training and TA with Ohio SAMI CCOE: Southwest Affiliation intends to contract with the Ohio SAMI CCOE to provide IDDT Team and Program Leader training and general overview COD training, as well as technical assistance and consultation for one year. Training will begin once baseline Fidelity Assessment has been completed.
- 2) Involvement in national COCE TA project on screening/assessment and welcoming: see above
- 3) Fidelity Assessment Team (MiFAST) training and representation: see above
- 4) Training in Human Service Co-Op (HSC) – Arizona Model development: Kalamazoo, along with Jackson, Montcalm, and Oakland Counties, have contracted with the Federated HSC to provide training on Co-op models and implementation. Since the above mentioned SAMSHA Peer-to-peer recovery grant, if funded, would fund peer-to-peer recovery provider services for COD peers, the Co-op would have the option on contracted with peer providers to complete direct service.
- 5) Participation in Cline/Minkoff training and Mee-Lee training at state level: Several staff from each County were able to take advantage of state-wide trainings by Drs. Cline, Minkoff, and Mee-Lee.

#### **G. Barriers to Implementation**

- 1) PIHP and CA borders: Southwest Affiliation has Counties that are in three separate Coordinating Agencies (Kalamazoo, Lakeshore, and Venture). This makes referral and fund braiding difficult. Efforts to true-up the PIHP/CA borders underway currently at the state level would have a major positive impact on the Affiliate's work on CID integration.
- 2) Two different models of CMHs (urban and rural): Kalamazoo County is an urban county, and one that contracts for most services. St. Joseph, Cass, and Allegan are all rural counties, and direct service

providers. The challenge of providing structure, training, and implementation that meets both situation's needs is not insurmountable, but adds an extra layer of complexity.

#### **H. Implementing Enhanced Service Model**

Although enhanced service models (IDDT teams) are not yet in place and determined ready for baseline Fidelity Assessment, two teams are approaching readiness in Kalamazoo (SAMB at InterAct of Michigan and Douglass Community Association). St. Joseph County is in the process of developing a proposal in collaboration with Community Healing Centers to augment the current ACT and ICM teams with services and providers to complete an IDDT team in Three Rivers. Cass and Allegan counties have teams in place who serve MI, SA, and COD consumers and are interested in assessment as an IDDT model. A readiness call is scheduled with Patrick Boyle May 31<sup>st</sup> to determine which of the above teams are prepared for Baseline Fidelity Assessment by a MiFAST team.

#### **I. Financial Support and Sustainability Planning**

KCMHSAS has been and continues to be fully financially supportive of COD:IDDT implementation. The expectation that effective, evidence-based treatment of CODs will become an important part of business as usual is embedded within this commitment. COD champions exist throughout the system, and are integrating into many other service areas such as corrections, prevention, and Methamphetamine efforts, enhancing integration and ensuring sustainability.

#### **J. Next Quarter Activities**

See attachment for updated RFP workplan and Action Plan approved by Improving Practices Leadership Team (attachment to updated charter document)

# THUMB ALLIANCE

## Co-Occurring Disorders Block Grant Narrative Report January 1, 2006 – March 31, 2006

- A. The Thumb Alliance PIHP continues to work within the star up domain of implementing the Co-Occurring Disorders [COD] Block Grant. Within this quarter, the Thumb Alliance Improving Practices Committee has developed and received Board approval on an Improving Practices Charter and has developed goals which reflect the themes and values expressed in the Charter and, in fact, reach beyond the Co-Occurring Disorders initiative.

Our Co-Occurring Disorders Workgroup, which reports to the Improving Practices Leadership Council, has assumed a leadership role in developing our implementation strategy.

Efforts continue to take place within the System Readiness and Access System Integration domains of the Strategic Action Plan. The Access Sub-Committee continues to work towards integration of the access functions for the public mental health and substance abuse treatment systems from both the clinical and technological standpoints. The Thumb Alliance has been participating with some of the state level discussion on integrated screening and access. As a related side note, the Thumb Alliance PIHP will no longer contract with the Thumb Region Substance Abuse Coordinating Agency for direct management of the Medicaid substance abuse system and will directly manage that network of providers effective April 1, 2006.

From a system readiness standpoint, the Thumb Alliance has been working towards initiating our baseline IDDT fidelity evaluation. In addition to participating in the state level trainings with Patrick Boyle and the state level workgroups, the Thumb Alliance has been in separate contact with Wayne State University to discuss their experiences with IDDT fidelity assessment and to seek consultation and assistance in applying that knowledge to our system. We are in the process of developing a contract with Wayne State for technical assistance and training in this area.

- B. The most significant process change activities from this quarter were the development of an improving practices charter and goals. These documents and the concepts expressed within them were endorsed by the PIHP Management Council and Board, reaffirming their commitment towards improving practices for public mental health consumers in the Thumb region.
- C. As referenced above, the first significant milestone was the development and endorsement of a Charter document for our Improving Practices Leadership Council, which was followed by the development of more specific goals and objectives to guide our actions in system transformation efforts. Both of those documents are attached.

- D. The discussion surrounding the new charter served as another consensus building activity at both the Management Council and Board levels. The document provoked discussion surrounding the outcomes that these groups envision for our consumers and our systems as well as providing confirmation of our alignment on major issues. The movement locally towards formal integration of the public mental health and substance abuse systems, with the eventual outcome of having the PIHP designated as the CA within the Thumb Region, has become somewhat intertwined with this initiative and has given added meaning to the discussion for some.
- E. The most significant progress to date is in the area of fidelity assessment. The Thumb Alliance completed the Co-Fit with key system leaders last quarter. In reviewing the results of that exercise, we found that it was quite difficult to use those results in any meaningful and practical goal/plan revision activities. This led us in the direction of Wayne State University. We became aware of their involvement in current IDDT fidelity assessment with Project Care through Board Association training and sought their consultation on our project. After discussion with several Wayne State University staff, we determined that completion of the IDDT and GOI fidelity scales at the baseline level would provide us with more practical assistance in guiding our system through transformation efforts. The Thumb Alliance PIHP is in the process of developing a contract with Wayne State University for training and consultation in this area. We have also consulted with Patrick Boyle regarding our proposed process and preparation. The Thumb Alliance has identified team members for our fidelity assessment team, sent our team leader to Patrick Boyle's training, and arranged for Wayne State to provide two days of training prior to our initiation of baseline fidelity assessment. While we would not be planning to complete the COMPASS and CODECAT assessment tools for some time [based upon expert recommendation], we are in the process of discussing their potential utility based upon the fact that we will already be using data collected via the IDDT and GOI assessment processes. If we determine that the completion of these two additional tools [in addition to additional administration of the Co-Fit] would not provide our system with added value, we may seek to amend our grant proposal to omit those tools in the interest of efficiency.

We have attached our Council Charter and Goals. We have decided not to make any major amendments to our work plan until we have had the opportunity to analyze the results of our system baseline fidelity assessment.

- F. We have had staff attendance at the recent trainings facilitated by Kenneth Minkoff and Christie Cline, as well as the training by Patrick Boyle in March. We have also participated in consultation with Patrick Boyle in March regarding fidelity assessment. We continue to have staff participate in the state level workgroups relative to COD, the sub-groups on Policy/Administration, Staff Development, and Outcomes Evaluation in particular. We maintain representation on the state level Practices Improvement Steering Committee. In